

**AUTHORIZATION FOR
RELEASE OF INFORMATION**

JD-CL-46 Rev. 4-06 C.G.S. §§ 10-154a, 31-128f, 52-146b to 52-146o

**STATE OF CONNECTICUT
SUPERIOR COURT**



www.jud.ct.gov

FROM (Full name of authorizing individual)	INFORMATION NEEDED BY (Date)
I ADDRESS	
II TO:	
III L	
INSTRUCTIONS	
<ol style="list-style-type: none"> Authorizing individual: In section II, specify hospital, school, physician, clinic, laboratory, pharmacy, insurer or other health care provider in possession of protected health care information; complete section VII and sign before a witness. Judicial Branch personnel: Complete sections I, III, IV, V and VI. 	

III. RELEASE INFORMATION PERTAINING TO:

NAME (Full name of Subject of Record)

DATE OF BIRTH

(Check if authorization is for information concerning a minor child)

IV. TYPE OF INFORMATION TO BE RELEASED

INSTRUCTIONS: The individual completing this authorization should be advised that this form may not be used to release both psychotherapy notes and other types of health information. If this form is being used to authorize the release of psychiatric health information, a separate form must be used to authorize release of any other health information. Authorizations for use or disclosure of sensitive health information (such as HIV/AIDS or substance abuse) should be initiated by the requestor.

("X" ALL THAT APPLY):

- Entire Medical Record
- Only information related to (specific diagnosis, injury, operation, etc.)

- Only the period of events from _____ to _____
- Billing Records
- Psychotherapy Notes ONLY* (by checking this box I am waiving any psychotherapist-patient privilege)
- School Transcript
- Other:

- I specifically authorize the release of the following sensitive information from my health record. (Initial all that apply)
 - ____ Substance Abuse (Alcohol/Drug)
 - ____ Confidential HIV/AIDS Related Information
 - ____ Mental Health (Other than psychotherapy notes)
 - ____ Sexually Transmitted Disease
 - ____ Genetic Testing

* PSYCHOTHERAPY NOTES means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of an individual's medical record.

V. PURPOSE OF AUTHORIZATION/DISCLOSURE

This request for disclosure is being made at the request of the individual for purposes related to the case identified in this section which may include, but not be limited to, court ordered investigation, supervision and mediation/negotiation:

COURT	JUVENILE	AT (Town)	DOCKET NO.
<input type="checkbox"/> JUDICIAL DISTRICT	<input type="checkbox"/> G.A. NO. _____	<input type="checkbox"/> MATTERS	

IF SUPERVISION, SHOW TYPE AND DURATION

VI. SEND INFORMATION REQUESTED TO:

COURT SUPPORT SERVICES DIVISION	ATTN: (Name of C.S.S.D. Officer or Counselor)	TELEPHONE
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OFFICE MAILING ADDRESS

VII. STATEMENT OF AUTHORIZATION

I hereby request and authorize the above-named person or institution to release to the Judicial Branch office specified above copies of the information requested as indicated in Sections III and IV of this form and I hereby authorize the Judicial Branch office to release that information, by making it available for inspection, including any sensitive information identified in Section IV, to the Court, to parties to the case, to counsel of record, and to any appointed Guardian Ad Litem. These recipients shall not further disclose such information except for legitimate trial and trial preparation purposes related to this case. I have read this form/had this form read/explained to me and I acknowledge an understanding of the purpose for the release of information. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on my authorization for this disclosure. I understand that I may inspect or have copies made of the information to be used or disclosed (excluding psychotherapy notes). I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization, in writing, at any time by sending such written notification to the person or institution named above, except to the extent that action has already been taken in reliance on it; or, except in the case of disclosure to those persons within the criminal justice system who have made my participation in a program or service provided by the above-named person or institution a condition of (1) the disposition of any criminal proceedings against me, (2) my release from custody or (3) my probation. This authorization, unless expressly revoked earlier, automatically expires as directed below.

SPECIFY DATE, EVENT OR CONDITION OF EXPIRATION, WHICH CAN BE NO LATER THAN THE FINAL DISPOSITION OF THE CASE

SIGNATURES	SIGNATURE OF AUTHORIZING PERSON	DATE SIGNED	SIGNATURE OF WITNESS		
If signed by a legal representative, indicate relationship to subject of record and provide the appropriate documentation to verify your authority (Parents excluded from documentation requirement):					
<input type="checkbox"/> PARENT		<input type="checkbox"/> GUARDIAN	<input type="checkbox"/> CONSERVATOR	<input type="checkbox"/> EXECUTOR OF ESTATE	<input type="checkbox"/> POWER OF ATTORNEY

DISTRIBUTION: ORIGINAL - Party holding requested information

COPY 1 - C.S.S.D. Office

COPY 2 - Authorizing Individual